MIDTERM EVALUATION OF THE USAID/JAMAICA FAMILY PLANNING INITIATIVES PROJECT (FPIP)

(532-0163)

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by

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APPENDICES

ABBREVIATIONS

AVSC	Access to Voluntary and Safe Contraception International
CA	Cooperative Agency
CDC	Centers for Disease Control
CPR	contraceptive prevalence rate
CPS	Contraceptive Prevalence Survey
CPT	Contraceptive Procurement Table
CSM	Commercial Social Marketing
CTS	Contraceptive Tracking System
DEMPROJ	demographic projections model
EIS	executive information system
FAMPLAN	Jamaica International Planned Parenthood Federation (IPPF) affiliate
FHI	Family Health International
FLE	family life education
FPIP	Family Planning Initiatives Project
FPLM	Family Planning Logistics Management
FPMD	Family Planning Management Development
GOJ	the Government of Jamaica
HCL	Health Corporation Ltd.
IEC	information, education and communication
IPPF	International Planned Parenthood Federation
IUD	intrauterine device
JSI	John Snow, Inc.
KEY	Knowledge and Education for Youth Program
LMIS	Logistics Management Information System
MAJ	Medical Association of Jamaica
MIS	Management Information System
ML/LA	minilap with local anesthesia
MOEC	Ministry of Education and Culture
MOH	Ministry of Health
MSH	Management Sciences for Health Project
NFPB	National Family Planning Board
NSV	no-scalpel vasectomy
OPTIONS	Options for Population Policy
OR	Operations Research
PATH	Program for Appropriate Technology in Health
RAPID	Resources for Awareness of Population Impact on Development Project
ROSE	Reform of Secondary Education
ServStat	service statistics information system
SOMARC	Social Marketing for Contraceptives Project
STATIN	Statistical Institute of Jamaica
TA	technical assistance
TFR	total fertility rate
TOT	training of trainers
USAID	United States Agency for International Development

UWI-FMU/ ISER	University of West Indies-Fertility Management Unit/Institute of Social and Educational Research
VSC	voluntary surgical contraception
WCJF	Women's Center of Jamaica Foundation

PROJECT IDENTIFICATION DATA

PROJECT TITLE:	FAMILY PLANNING INITIATIVES PROJECT
COUNTRY:	JAMAICA
PROJECT NUMBER:	532-0163
PROJECT DATES:	
Agreement Signed:	7/23/91
End Date:	7/31/98
PROJECT FUNDING:	
Authorized LOP funding:	US$7,000,000
Funding to Date:	US$3,074,179
Host Country Funding:	US$2,734,000

MODE OF IMPLEMENTATION: NATIONAL FAMILY PLANNING BOARD

RESPONSIBLE USAID OFFICIALS:	
Mission Director:	Carol Tyson
Project Officer:	Grace-Ann Grey

PREVIOUS EVALUATIONS: NONE

EXECUTIVE SUMMARY

Operating since the 1970s, the Jamaica family planning program is widely regarded as a successful, mature program. USAID has supported family planning in Jamaica for more than 15 years. The current Family Planning Initiatives Project (FPIP) was authorized in 1991, launched in 1992, and is scheduled to end in 1998. This is intended to be USAID's final bilateral family planning project with Jamaica.

The goal of FPIP is to maximize the quality and quantity of family planning services in Jamaica delivered by the public and private sectors to support national development goals related to population. The project purpose is to increase program effectiveness and sustainability of the national family planning system in preparation for USAID phaseout.

The project aims to: shift the focus of the National Family Planning Board of Jamaica (NFPB) from its role of program implementation to a role of oversight and advocacy for family planning; shift the predominance of supply methods of contraception to more long-term and effective methods; shift some of the public sector service recipients into the private sector; and expand the role of private sector physicians and pharmacists in providing family planning counseling and methods.

The NFPB, the major counterpart of FPIP, is a statutory board established in 1970 as the principal agency of government responsible for preparing, carrying out, and promoting family planning and population programs in Jamaica. FPIP is funded under a seven-year grant of US$7 million. Of this amount, the USAID Mission had obligated US$5.24 million as of December 31, 1994; and USAID/Washington had obligated US$1.16 million for centrally procured contraceptives. Of the total amount of US$6.4 million obligated under the project, the total disbursement to date is US$3,074,179. This amount includes US$968,000 for centrally-procured contraceptives. The counterpart contribution by the Government of Jamaica (GOJ) for the life of the project is US$2,734,000.

It is important to note that FPIP is one project within the NFPB, and that the national family planning program encompasses the programs of the NFPB and other agencies in the public and private sectors.

FPIP is a well-designed project with many ambitious subprojects aimed at creating change in specific areas. Much progress has been made toward addressing these areas, and there are, of course, areas that need continued attention.

KEY ACHIEVEMENTS

The contraceptive prevalence rate (CPR) has increased dramatically from 55 percent in 1989 to 62 percent in 1993.

An impressive array of outstanding policy research and analysis has been conducted for the project, on which much of the programming has been based.

The Women's Center projects are under way, with a terrific response from the adolescent

community and their parents in the limited areas where it is operating.

The NFPB has been very successful in implementing the Top-Up contraceptive logistics delivery system island-wide; it has improved record keeping, is popular with clinic staff and has all but eliminated stock-outs.

The major part of the Contraceptive Tracking System (CTS) design and implementation has been completed and is currently being utilized by the NFPB warehouse staff.

The USAID phase-out (NFPB phase-in) for contraceptive procurement is proceeding on schedule, and contraceptives have been entered as a line item in the GOJ budget.

In November 1993 the NFPB met the USAID Conditions Precedent to divest the Commercial Distribution of Contraceptives program, which opened the door to the Social Marketing for Change Project's (SOMARC) assistance in starting the Personal Choice social marketing program.

The Personal Choice campaign has embarked on a wide range of successful activities including training, extensive mass media campaigns, and public relations.

In November 1994 the Conditions Precedent were met for the funding of the Family Life Education Program (FLE); the subproject proposal has been finalized and is awaiting the official authorization of the Ministry of Education and Culture.

Two new computers have been acquired and installed; the Service Statistics Software has been installed and is operational; an MIS training workshop was held in October 1993.

KEY ISSUES

The Advocacy Strategy has been slow in starting. In order for the NFPB to advocate successfully for the GOJ's continued financial and material support for the national family planning program, it needs more time to develop a range of advocacy techniques and skills. Constraint: the Options for Population Policy Project (OPTIONS II) buy-in ends in September 1995.

The hiring of a logistics manager, which has been recommended repeatedly for years, has not yet been completed, although the position has been advertised. Constraints are related to position and salary approval from the Ministry of Public Service and reluctance of some NFPB staff to relinquish parts of their roles.

The NFPB is not yet able to conduct forecasting and procurement procedures independently, and further technical assistance must focus on transfer of technology rather than provision of services.

Three separate logistics systems are running concurrently (the main NFPB system, one for Depo-Provera, and one for condoms purchased for the Epidemiology Unit of the Ministry of Health [MOH]), which complicates the forecasting and procurement of commodities.

The functions that would have been served by subcommittees of the board of directors (financial oversight, medical expertise to consider ideal method mix and means to shift toward it, direct attention to sustainability issues) are not being performed because those subcommittees have not been appointed. Constraint: the Minister of Health has not yet appointed a full board of directors who would appoint the subcommittees.

KEY RECOMMENDATIONS

1) The OPTIONS II project should be given a no-cost extension for 8-12 months so that ongoing technical assistance can be provided to develop the advocacy function of the NFPB.

2) The SOMARC project should receive additional funding and a one-year extension of its buy-in to give the Personal Choice program adequate time and support to prove its value to the distributors, whose commitment to the program during this start-up time is crucial to its long-term success.

3) USAID should work closely with the Minister of Health and the Permanent Secretary to help the NFPB to gain the institutional support it needs to reconfigure itself in order to continue to be a credible guardian of the national family planning program.

4) USAID should urge the NFPB to frame the upcoming organizational development as a strategic planning and organizational development exercise to determine how it will carry out its new roles and support programs over the next 5-10 years, and how it can work more productively with its colleagues.

5) USAID should conduct an audit of the Commercial Distribution of Contraceptives funds and the income from the sale of Noriday. A strategy should be developed for the use of these funds, to include support for procurement and for the Personal Choice advertising campaign.

6) The Family Planning Management Development, with USAID and the NFPB, should carefully reconfigure its remaining time and funding in order to complete some of its essential activities, particularly on the accounting software. If additional time and funding is necessary for completion, it should be granted and carefully monitored. The Executive Information System (EIS) and the Logistics Management Information System/Management Information System (LMIS/MIS) link should be abandoned.

7) It is essential that the hiring of a logistics manager be completed, and that the individual be fully trained and fully authorized to direct the forecasting, procurement and logistics operation for the NFPB.

8) Implementation of the Family Life Education Program should be started as soon as the project is approved, and many activities should be conducted simultaneously to speed its introduction to schoolchildren.

9) The NFPB should develop a plan for the phasing in of the procurement of all other contraceptives (in addition to the condoms they are now procuring), and locate manufacturers/distributors from whom they can purchase commodities in the absence of the International Planned Parenthood Federation's (IPPF) services. It is essential that additional technical assistance focus on the transfer of technology in forecasting and procurement of contraceptives, and that a new logistics manager be in place to manage the integration of the technology into the NFPB.

10) Even though the Minister of Health has not appointed a full board of directors, the functions of the finance, medical, and sustainability committees need to be addressed, and alternative structures should be designed.

11) The three contraceptive logistics systems should be integrated for more accurate and efficient operation.

12) The training agenda for the NFPB's institutional development should be developed immediately with USAID, and should include management, leadership and supervisory training for those in the designated roles; and computer training for statistical and accounting staff.

1 INTRODUCTION

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1 Context of the Evaluation

The project agreement was signed in July 1991, shortly before the discovery of an incident of fraud in the financial offices of the NFPB in the amount of approximately US$50,000. This resulted in the decertification of the NFPB from receiving advances or directly disbursing funds from USAID, which had been the practice in previous projects. (Although the mechanisms for recertification are relatively straightforward, the NFPB has not met the criteria for a USAID audit which would lead to recertification.) While previous projects have authorized the NFPB to do its own contracting for technical assistance and other services, for this project USAID developed buy-ins with six Cooperating Agencies (CAs). Each CA has its own contract with USAID rather than with the NFPB, and several have developed subcontracts with Jamaican research or consulting firms. The decertification and the bypassing of the NFPB in the contracting process may have contributed to its demoralization and apparent and reported difficulties in accepting the technical assistance of the CAs. Rather, the CAs are treated (and perhaps act) as contractors who are expected to produce the deliverables instead of transferring skills and technologies to the staff of the NFPB to enable them to carry out the work themselves. It is not clear how much of this difficulty in transferring technology is attributable to the NFPB and how much to the CAs.

The evaluation team found the NFPB had not prepared itself for the evaluation, nor had it thoughtfully engaged other relevant agencies or institutions in preparing for the visits of team members. Information that should have been compiled for an evaluation was not readily available, and even when requested was not always provided.

It should be noted, however, that this is an evaluation of the FPIP, not of the executing agency; and while there are management and technical problems in the NFPB, the momentum of the project is strong, and it is moving toward its goals and objectives with very promising outcomes. Clearly, the Jamaica family planning program is worthy of ongoing, focused USAID support for its innovative programs.

1 Methodology of the Evaluation

The evaluation team consisted of Mary Wright, RN, MS, MPH, team leader; Naomi Blumberg, MPH; and Hermione McKenzie, MA. The team reviewed existing project documents and consultant reports as background on the project, including numerous studies, position papers, background briefings, and trip reports. It should be noted that a prodigious amount of important, thoughtful, and high quality research has been conducted to develop the bases for the interventions in this project, and that research greatly enriched the team's ability to understand the project more deeply and broadly than two weeks of fieldwork alone could have provided. In addition to the review of documents, interviews were conducted with many of the NFPB staff as well as representatives of the six CAs, the Jamaican subcontractors, the government ministries, and local nongovernmental organizations (NGOs). A bibliography and the list of persons contacted are found in Appendices B and C respectively.

The content and organization of the evaluation report are guided by the Scope of Work, found in Appendix A.

1 RESPONSES TO SPECIFIC QUESTIONS IN SCOPE OF WORK

Many individual questions were specified in the Scope of Work; those that have been clearly answered in the body of the report are not repeated here.

1 Progress Toward Objectives

To date, what has been the impact of FPIP on the contraceptive prevalence rate (CPR), on public to private shift, and on each of the project component areas?

It is extremely difficult to measure the impact of a project as large and complex as FPIP, particularly in the light of all the other efforts being made in related fields. However, the Contraceptive Prevalence Survey (CPS) notes that the CPR increased from 55 percent in 1989 to 62 percent in 1993, largely due to the 86 percent increase in the use of condoms. While it is difficult to attribute this gain to any particular project, the increase is a likely indicator of significant progress under the FPIP. As a result, the family planning program is no longer aiming at 62 percent CPR, but at reaching replacement fertility by 2005.

While some training has taken place in the private sector, and the Social Marketing for Contraceptives Project (SOMARC) is on schedule but not yet complete, the major Private Provider Project has only been operational for two months. The 1993 CPS showed that women (ages 15-44) obtained their contraceptives from the private sector as follows: 48.2 percent of pill users, up from 34.5 percent; 60.7 percent of condom users, up from 54.9 percent; 6.5 percent of injectable users, down from 7 percent; and 7.3 percent of sterilizations, down from 11.4 percent in 1989. So there has been a shift from public to private sectors in the pill and condom purchase, but a shift from private to public in injectable and sterilization services. These shifts are probably related to cost and availability of services.

Comment on how the project activities will continue to support the overall objectives of FPIP. Are project assumptions still relevant? Has the level of technical assistance and/or training changed? Are there any changes or modifications required at this time?

Because this is a midterm evaluation, there are many aspects of the project that are still in preliminary and planning stages. A good beginning has been made on several of them, and commitments have been made to support others; those to which commitments have not yet been made need to be addressed. Components that are not yet fully in place include: active engagement with the advocacy role, which requires a no-cost extension for the Options for Population Policy Project (OPTIONS II); long-term commitment of the social marketing distributors, which requires additional funding and a minimum one-year extension for SOMARC; a fully authorized logistics manager; rapid implementation of the Family Life Education (FLE) project; successful promotion and implementation of the ambitious Private Providers Project; reconfiguration of the Management Information System (MIS) activities; and very importantly, implementation of organizational development for the NFPB.

Most project assumptions are still relevant, but the fact that the Minister of Health has not appointed a full board of directors is worrisome, in that the NFPB feels hampered by this (i.e., it cannot appoint any subcommittees), and has not been able to gain the Minister's attention to this

issue. A great deal of technical assistance (TA) has been provided to the NFPB; but there has not been a corresponding amount of technology transfer, and if this does not increase dramatically, the sustainability of the NFPB's role (as described in the FPIP paper) is at risk.

Because nearly all of the obligated funds have already been committed, it was agreed with USAID/Jamaica that there was little point in devoting time to suggesting major modifications in the spending plan. It is very important, however, that SOMARC receive additional funding and a one-year extension for the social marketing program (see 4.4.7); that OPTIONS II be granted a no-cost extension of 8-12 months; and that Family Planning Management Development (FPMD) have sufficient funding to consolidate and complete its essential work on the basic components of the MIS.

Are more men and women using contraception, and has there been a shift toward long-term and permanent methods?

The 1993 CPS suggests that 48.3 percent of all women are using a contraceptive method as compared to 43 percent in 1989; and 56 percent of men report that they or their partners are currently using a method, with no comparison data collected previously.

The method mix among women did not change during the six-year period between 1983 and 1989. During that period, the most prevalent method used in Jamaica was oral contraception, followed by female sterilization, the condom, and injectables. Change in condom use was relatively minor during the six years, increasing from 7.6 percent in 1983 to 9.1 percent in 1989--an increase of 20 percent. The rise in condom use between 1989 and 1993 from 9.1 percent to 16.9 percent was much more dramatic--an increase of 86 percent--accounting for most of the increase in overall contraceptive use in this time period. The increase also brought the condom up to second most prevalent method that women in union reported.

Among men in union, one-third reported that they use the condom as their primary method, about twice the percentage of women who report condom use. About 21 percent of men reported that their partners use the pill, with lower prevalence reported for female sterilization and injectables--methods whose use the men may be unaware of.

The team's informal survey of nurses and clients at several rural and urban clinics indicates that the most favored method by far is currently the injectable. This signals a shift in method mix in the direction sought by FPIP.

The USAID Project Status Report for the period October 1993-March 1994 reports a reduction in the use of long-term methods from 42 percent in 1989 to 31 percent in 1993. This may be due primarily to the dramatic increase in condom use occurring in the same time interval, since the use of sterilization, injectables, and IUD did not vary so dramatically.

In summary, while a shift toward long-term and permanent methods was not yet demonstrated in the 1993 CPS, the FPIP was not fully operational until May 1992, and it would be unrealistic to expect any major results in such a brief time. Clearly, at this time, more information is being communicated to the public, more providers have been trained, and more long-term and permanent methods are being provided now than in 1993.

1 Project Management and Implementation

How are issues resolved when identified by the steering committee, CAs, or USAID during the course of implementation?

As far as the team was able to ascertain, some concerns that are raised by the Project Implementation Committee (which is assumed to be the steering committee), CAs, and USAID have been brought to the NFPB's attention and have been addressed. These include concerns such as the initial delays in granting concurrences (which was solved by simplifying the process); the poor communication between the Ministry of Health (MOH) and the NFPB is being addressed by the revival of the Family Planning Coordinating Committee. There are many concerns, however, that have been repeatedly brought to the NFPB by all these bodies and that have not been addressed, such as the lengthy delay in hiring a logistics manager (a recruitment effort began in May 1995), lack of integration of Depo-Provera into the Top-Up system, and the absence of an acceptable training plan. While some problems have been solved, the NFPB does not engage collaboratively in problem-solving activities. For example, the NFPB was "surprised and taken aback" by the team's observation that it had difficulty working together with USAID to determine a mutually acceptable training plan. The NFPB cites its view that "USAID's preset agenda and refusal to accept the training needs identified by the NFPB have created this situation." But rather than discussing the conflict directly with USAID/Jamaica and developing a mutual understanding of the problem and an agreed-upon solution, the NFPB simply submitted a new plan—thus, three of their plans have been rejected. While this example of difficulty in collaborating does involve two players, USAID and the NFPB, it is clearly in the NFPB's interest to capture the opportunities to train its staff in whatever areas USAID deems relevant for funding. Its refusal to work with what is available, even if it is not ideal, leads the team to the conclusion that the NFPB has difficulty working with its colleagues.

Is the NFPB able to play the focal role envisioned? If not, why, and what events or circumstances have affected the NFPB's performance?

It is not clear at this time that the NFPB will be able to take up the roles of coordinator and advocate for the national family planning program as those roles are described in the Project Paper. This is due to a combination of circumstances beginning with the fact that the individuals who designed and signed off on the project are no longer with the NFPB, leaving a new executive director and a new board of directors to implement the project. In addition, the fraud that was discovered around the time of the project authorization led to the NFPB's decertification, which has dealt a crushing blow to its institutional self-esteem, and has doubtless increased the demoralization of the underpaid staff.

There is reason to believe that as the intensive TA with OPTIONS II becomes available this spring, the NFPB will demonstrate greater interest in its advocacy role, which may result in more effective action. In addition, if the organizational development consultancy is carefully developed and seriously undertaken, it might help to create more effective working relationships and structures.

Should USAID continue to strengthen the NFPB?

The evaluation team suggests that supporting the internal structure of the NFPB might not be the most cost-effective way to continue to support Jamaican family planning efforts after 1998. The NFPB is a large, cumbersome organization constrained by its status as a statutory board, which makes it difficult to reorganize itself as an effective advocate and coordinator of activities. For the short term, the team suggests that USAID focus its energy on high-level engagement with the Minister of Health and the Permanent Secretary to generate strong MOH support for the NFPB so that it can reorganize itself to take up its new role on behalf of the family planning program. USAID should continue to use the NFPB as a contact point for specific activities contingent on the NFPB having personnel and funding available, and to focus its financial support on specific NGO activities run by organizations with strong track records.

What can be done to further expand the use and availability of longer term methods?

Sterilization - In informal conversations with clinic nurses and clients, the team was told stories about women who had decided to have tubal ligations and arrived for their appointments only to be told that the physician could not be there. In most of these stories, the women took it as a sign that they should not proceed, and they continued with their previous method of contraception without re-scheduling for the procedure. There were also many reports of women not showing up for scheduled procedures, even after a careful counseling and decision-making process. Even though the sample was minuscule, it seems to indicate the difficulty women have in deciding on sterilization, and therefore it is crucial that physicians manage their schedules so they can be at the site as promised.

NORPLANT® - Another important variable to address is the proficiency of physicians to insert and remove NORPLANT® implants so that women will not be exposed to discomfort or disfigurement. Physicians and counselors also need to provide information and referral services related to the method. The key concern about the viability of NORPLANT® as a public sector method is its prohibitive cost, which would require that the GOJ bear the expense if it is to be widely accepted.

Depo-Provera - Physicians and nurses need additional training in the management of the use of Depo-Provera so that women who are distressed by side effects such as breakthrough bleeding can be regulated with small doses of oral contraceptives, or helped to accept the side-effects more comfortably.

Primarily, there is a need for massive education and information about long-term contraceptive methods to counter the myths and rumors generated by infrequent complications, fertile imaginations and a good deal of sensationalism. Method-specific public information, whether in print or on TV and radio, and extensive outreach to radio and TV call-in show hosts, as well as advertising through musical jingles, will bring increased awareness to the public. In addition, surveys indicate that physicians are a major source of misinformation. Informational outreach about long-term methods should therefore be provided in large quantities to general practitioners, internists, and obstetrician/gynecologists through specialty journals and newsletters.

Given the budget, is the GOJ capable of sustaining the financing of family planning

services, including recurrent costs for contraceptives, clinical equipment, clinical training and counseling training, IEC, and policy?

Team members were not able to meet with an adequate range of MOH personnel. We met with two MOH managers, and spoke with others outside the MOH who claimed to be familiar with the views of the ministers of health and finance. We cannot predict what policy changes may occur, or what changes in government may occur which may precipitate a change in policies relating to family planning. However, it does appear that the GOJ budget is capable of sustaining the financing of family planning. The inputs of the GOJ to the NFPB have been relatively stable over the past seven years, and have even shown an increase in real terms between 1993 and 1995. This increase largely reflects the support from a World Bank project (JPHP1), which has begun to taper off in the 1995–1996 budget. It should be noted that the cost of family planning represents a very small proportion of the overall health budget (1 percent or less, and represents a minuscule proportion of the overall GOJ budget. The purchase of contraceptives has become a line item in the MOH budget, and funding has been provided regularly to the NFPB in the amount requested. This track record, however brief, is very good news, and is reported to be taken as an indication that the GOJ's commitment to the purchase of commodities is strong and reliable (see GOJ Budget, Appendix D).

The MOH has the capacity to provide clinical training and counseling training. In this and previous projects, trainers have been trained by CAs to provide training in counseling and in family planning to nurses and alternative health workers; however, since it is reported by the NFPB that MOH funding has never been available for training, the will to provide it in the future is questionable. Physicians in the community have been trained in no-scalpel vasectomy (NSV) and minilap with local anesthesia (ML/LA), and some have been trained as trainers. It is incumbent on the NFPB and the MOH to work collaboratively to help these trainers maintain their training skills by providing them with opportunities to train, and periodically to learn, new training skills and techniques.

The information, education and communication (IEC) function is firmly lodged in both the NFPB and the MOH systems, thanks to the five-year World Bank loan/grant that is coming to an end. The NFPB clearly possesses the greater skill in applying IEC concepts to family planning, but it is not difficult to imagine that the MOH could develop that capacity by accessing the NFPB expertise.

Is enough being done to reach adolescents?

While there are several NGOs addressing the needs of adolescents in reproductive health and family planning, and the World Bank is sponsoring a far-reaching IEC campaign targeted at adolescents, it is clear that this group requires massive and personal interventions to prevent pregnancy, especially in the context of Jamaica's culture in which sexual expression is very overt and explicit. The extensive exposure of adolescents to sexually explicit TV and radio soap operas, advertising and music, and the reduction in the age gap between parents and children contribute to early sexual activity among boys and girls (16.1 percent of women report their first sexual activity occurred before age 15). Given these cultural pressures, it is crucial that personal interventions like counseling and focused family planning education be provided in order to capture the attention and interest of youngsters who are, developmentally, easily distracted and easily influenced by peers and exposure to media.

Programs such as those provided at the Women's Center are likely to offer the best success in helping youngsters delay sexual activity, as indicated by the Center's success in its program to delay second pregnancy. The evaluation research that will be conducted by Family Health International (FHI) on the Women's Center Knowledge and Education for Youth (KEY) and Grade 7 projects will provide specific information about which elements of the programs have the strongest impact on youngsters. These kinds of programs should be the focus of local and donor funding, because preventing the onset of a lifestyle of high fertility and helping young women to find their way into education and productive employment will provide them with a stronger capacity to make thoughtful decisions about their reproductive lives.

The Women's Center project to delay second pregnancy has been highly successful, with only 1.1-1.4 percent of participating girls under 16 becoming pregnant for a second time before attaining their educational and employment goals. This astoundingly low figure should be sufficient to demonstrate that expansion of the Women's Center programs and/or development of similar programs should be funded immediately. The study of the new program's success can only enhance the findings that are already available.

Is technology being transferred?

Some technology is clearly being transferred: the successful implementation of the Top-Up Logistics System and the larger part of the Contraceptive Tracking System (CTS) are examples. In large part, however, the CAs have tended to function like contractors and provided technical services and deliverables rather than technical assistance. It is unclear whether this is a reflection of the NFPB's difficulty or unwillingness to learn, or of the CAs focus on delivering the service. Some obstacles to technology transfer are described in Chapter 5.

Who are the MOH and NFPB's key players, and what are their responsibilities *vis a vis* monitoring and evaluation of clinical methods. How are infection prevention practices monitored and maintained?

Monitoring and evaluation of clinical methods are done by the medical director of the NFPB, and the voluntary surgical contraception (VSC) coordinator and family planning coordinator based at the MOH. These nurse-coordinators make frequent site visits, observing the techniques of service delivery in the clinics and operating theaters, talking with doctors and nurses who deliver the services, and reporting their findings at meetings with the medical director at the NFPB and Family Planning Coordinating Committee meetings. It would be an overstatement, however, to say that either the monitoring or evaluation of service delivery is systematic.

How has the development of the 1992-1998 strategic plan assisted in the timely implementation of project activities? Should adjustments be made to the strategic work plan at this time?

The strategic plan assigned responsibilities for key activities to specific entities, and in so doing, brought the tasks to the full attention of the responsible parties. This could have encouraged prompt start-up and effective assumption of the relevant responsibilities. However, a review of

the tasks allocated in the strategic plan indicates that the tasks were not initially allocated with an emphasis on the time frame, but on the entity responsible. Second, of 16 key tasks, about eight have shown marked progress over the two years since the strategic plan was written. Three of those eight were largely achieved by the CAs rather than by local counterparts. The remainder show limited or doubtful progress.

The MIS activity has not been achieved as projected, and should be considered for reconfiguration and rescheduling.

The following tasks have not been completed and rescheduling is recommended:

- OPTIONS II computer graphics software (PowerPoint) training, originally scheduled for May and July 1994
- policy communications materials, scheduled for May-November 1994
- policy-makers' study tour to Mexico, scheduled for November 1994 and January 1995, which were suggested by USAID but not funded
- CA review and planning meeting in Jamaica, scheduled for February 1995, postponed by mutual agreement

Have counterpart contributions and MOH inputs been received in a timely manner?

Officials of the NFPB report that MOH contributions are received promptly.

How will the MIS data be reported?

MIS data will be reported to USAID through quarterly and annual reports, which have thus far met USAID's needs.

1 Financial Analysis

Are project funds being spent in a prudent and efficient fashion?

Since the NFPB is decertified, local funds are administered directly by USAID/Jamaica, and all other funds are managed by the CAs. The accounting of the CAs' expenditures is reportedly unavailable to USAID/Jamaica for as long as six months if it waits for USAID/W to send reports. It is suggested that requests to the CAs would probably yield an earlier response. The Options II project submits quarterly reports to USAID/Jamaica. It therefore appears that no one is monitoring the expenditures for the entire project as they occur.

All indications are that project funds are being spent prudently and efficiently.

Are financial status reports accurate and submitted on a timely basis? Are project expenditure reports tracking project cost by line item? If not, why not?

Much of the funding of this project is assigned to buy-ins from CAs. CAs reportedly draw-down

their funds from USAID/Washington, and appear to manage their own project expenditures. Thus:

a) advice of draw-downs may reach USAID/Jamaica as late as six months after funds have been disbursed by USAID/Washington. This means that USAID/Jamaica records are not usually up to date.

b) USAID/Washington may have greater responsibility for monitoring project expenditures than USAID/Jamaica.

The evaluation team polled the CAs to determine whether the financial reporting requirements are being met by their subcontractors. The results are as follows:

The Association for Voluntary Surgical Contraception (AVSC) subcontracts with:

The Women's Center - financial status reports are generally accurate and timely, with occasional lapses when changes occur either on the GOJ side or the AVSC side. At such times, additional technical support is provided to assist the finance department to make the necessary changes; and the staff is responsive to requests for revisions. Expenditure reports are tracking project costs by line item.

The NFPB - since the resolution of an incident involving misuse of the AVSC checkbook, reports are more accurate and timely. The medical director has taken over the programmatic control of the subproject, and those reports are submitted on time. Actual financial reports arrive somewhat later, but this is not viewed as problematic. Project costs are being reported by line item.

The OPTIONS II project subcontracts with:

T. Hamilton Associates
Psearch Associates, Inc.
University of West Indies-Fertility Management Unit/Institute for Social and Educational Research (UWI-FMU/ISER)

All these subcontracts were fixed-price contracts requiring only deliverables and no financial reporting.

FHI subcontracts with:

Medical Association of Jamaica
Ministry of Health
McFarlane Associates

Financial status reports for all subcontractors are accurate and submitted on time; project expenditure reports are tracking project costs by line item.

Is the FPIP being managed efficiently and effectively by USAID/Jamaica, the NFPB,

and the CAs?

The project is meant to be a collaboration between the NFPB, USAID and the CAs. The decertification of the NFPB effectively deauthorized it as the executing agency, which leaves the project manager without a real portfolio, and the project without a clear manager. In the absence of someone who is accountable for the management of all aspects of the project, many issues have gone unaddressed and unresolved. Had the roles of each of the three parties been revisited and redefined once the fraud was discovered and the NFPB decertified, the responsibility and authority of the players would have been more clear to each of them, and the evaluation of their effectiveness more straightforward. It is still possible that an effective organizational development exercise might conduct that reassessment and lead to a more positive outcome by incorporating the key people from USAID and the CAs for a part of the exercise.

USAID provided a good deal of financial information to the evaluation team; still unclear, however, is the discrepancy between USAID's identification of an unearmarked balance of US$1,637,639, vis-a-vis earlier conversations with the project officer and the NFPB director who indicated that only US$200,000 remained. The NFPB delays in granting concurrences were a problem early in the project, but improved administrative practices have largely eliminated those delays. CAs manage their own projects with no apparent problems. It should be noted that having taken up the leadership role among the CAs, OPTIONS II has worked successfully to coordinate CA activities through Washington-based meetings with the CAs and Jamaica-based meetings with the CAs, USAID, and the NFPB. It was at the latter meeting that the 1994-1995 monthly work plan was developed in an effort to more systematically organize and schedule CAs visits.

1 POLICY FRAMEWORK

The policy framework component of the project is intended to ensure that the appropriate policies and programs are in place within the GOJ to support sustainable family planning services, and that relevant data are available as a basis for policy decisions. This involves identifying the areas of population studies that are relevant to the Jamaica context; developing and conducting research that will respond effectively to the questions raised; communicating the results of the research to decision makers and influential people in the public and private sectors who can integrate population concerns into their planning and development strategies; and applying the results of the research to the design of the activities of the family planning program.

The achievements are an impressive array of high-quality, wide-ranging studies, policy analyses, and surveys that have been conducted, documented, and used to inform the development of program components.

1 Policy Analyses (US$195,000)

The following studies have been conducted, and their results applied as indicated:

- Privatization and Cost Recovery Options for the Jamaica Family Planning Program: A Background Analysis (Janet Smith and Betty Ravenholt, 1991)[1]

- Strategy for Increasing Private Sector Involvement and Cost Recovery in Family Planning Service Delivery in Jamaica (Janet Smith and Betty Ravenholt, 1991)[2]

- Study of Sustainability for the National Family Planning Board in Jamaica (M. Clyde, T. Levy, J. Bennett, 1992)

  These studies have been used to inform the following: the planning and implementation of the divestment of the NFPB's Commercial Distribution of Contraceptives program; the conceptualization of the strategy to shift an appropriate segment of the population from public to private sector contraceptive services; and the development of a social marketing effort.

- Report on Study Conducted Among Private General Practitioners (Hope Enterprises, 1991)[3]

- Family Planning Service Delivery Practices of Private Physicians in Jamaica (W. Bailey, O. McDonald, K. Hardee, M. Clyde, M. Villinski, 1994)

- Mapping Study and Private Physicians' Survey: Opportunities for Expanded Family Planning Services in Jamaica (W. Bailey, M. Clyde, S. Smith, A. Lee, J. Jackson, P. Oliver, J. Munroe, 1994)

[1] This study was conducted in preparation for FPIP but not as part of the project.
[2] This study was conducted in preparation for FPIP but not as part of the project.
[3] This study was conducted in preparation for FPIP but not as part of the project.

- Focus group study, (Psearch Associates, Inc., 1994)

  These studies revealed important information about physicians' knowledge, attitudes, and practice in relation to family planning, and located the points of service availability. The information about physicians' knowledge and attitudes toward family planning was used to develop education and training programs to equip physicians to deliver accurate and sensitive information to the increasing number of women seeking family planning services from them. The Mapping Study provided useful information in selecting sites for a pilot project which would recruit private physicians to provide family planning services.

- Analysis of the Legal and Regulatory Environment for Family Planning in Jamaica (B. Ravenholt, M. Clyde, 1995)

  This study provides the foundation for the NFPB's advocacy efforts. It identifies areas for the NFPB to work with various ministries of the GOJ to open up all the possibilities for expanding and enhancing the provision of contraceptive services to women and men of all ages in the public and private sectors.

While the two marketing presentations and three seminars for decision-makers on method mix (cited in the Project Paper) have not been conducted, far more than two policy analyses have been completed and thoughtfully utilized; and OPTIONS II reports that the Advocacy Strategy document developed in January 1995 will galvanize the activities related to influencing the decision-makers and move into action shortly. The staff and board of the NFPB were actively involved in the strategy workshop activity.

It should be noted, however, that while the shift of the NFPB's role from implementers to overseers and advocates for family planning is a major feature of this project, the Advocacy Strategy has only recently been developed, and new activities have been slow in getting started. Advocacy for family planning has historically been part of the NFPB's role, and these new activities require a systematic approach to advocacy applying research findings for decision making.

The director reports that the Resources for the Awareness of Population Impact on Development Project (RAPID) StoryBoard presentation has been used at various fora including presentations to USAID's Mission director and MOH staff, FMU, private agencies, Planning Institute, and at population conferences in Jamaica and Antigua.

"The RAPID Program is no longer used because it is considered unrealistic. The DEMPROJ demographic projections model has been introduced but is incomplete and more reliable information is available. Scenarios from the target cost models were developed and utilized in preparation for the annual reports prior to the visit of the TA who mainly addressed mechanical problems."

1 Operations Research and Surveys (US$415,000)

1 Findings

While a few ideas for operations research were mentioned, no one reported any particular interest in such research, and since none has been undertaken, the funds were reprogrammed. Other studies, and opinions uncorroborated by research, have led to the development of creative methods of delivering various services (for example, the training of non-health workers as family planning counselors in hospitals).

The Centers for Disease Control (CDC) is responsible for the two Contraceptive Prevalence Surveys (CPS), the first of which was carried out as scheduled in 1993 through a subcontract with McFarlane Associates and the Statistical Institute of Jamaica (STATIN). The survey was completed on time, and dissemination seminars were held at the national and regional levels with good attendance and a great deal of interest. The second CPS is scheduled for early 1997.

An evaluation of the Women's Center project will begin shortly, as described in Chapter 4, and will be carried out by FHI in a project complementary to FPIP.

Other surveys that were conducted include:

- Needs Assessment of Select Voluntary Sterilization Service Sites (Alison Ellis et al., AVSC, 1991)

  The results of this survey contributed to the planning for future assistance to the national voluntary sterilization program and to the development of a long-term strategy for strengthening the national voluntary sterilization program.

- Public Sector User Survey for Women 15-49 Years (Hope Enterprises, 1991)[4]

  This survey provides information about who uses public clinics, why, and what the advantages and disadvantages of using them are. It was useful in determining what kinds of services women might be willing to pay for in the private sector, and in establishing some baseline ideas about pricing.

- Consumer Attitudes and Behaviors Regarding Contraceptive Methods in Jamaica: A focus group exploration (Psearch Associates, 1994)

  This is being used, in conjunction with other research, to design the pilot project to expand the role of private physicians in family planning services, and to expand the social marketing concept to the physicians.

Conclusions. A wealth of important information has been gathered and documented in the studies and surveys commissioned by the FPIP. All of it has been used to inform the design of particular aspects of the project, and information has surfaced that has generated new ideas for project activities. Fortunately, the flexibility of funding has allowed for the implementation of these new activities. The studies and surveys are important markers in the history of family planning in Jamaica, and hopefully, they will be safeguarded for future generations.

[4] This survey was conducted in preparation for the FPIP, but not as part of the project.

While program design was one reason to conduct these analyses, studies, and surveys, another major reason for them was to develop information that could be organized and used to advocate for major government investment, both financial and operational, in the national family planning program. Printed materials, seminars, public and private meetings were envisioned as a means of communicating to decision-makers and policy-makers the various different impacts of population growth on socioeconomic development in Jamaica. This aspect of the project is known as the Advocacy Plan. It was difficult to get it started and was about a year behind schedule in its start-up. It is slow in being implemented. The Advocacy Strategy was developed in January 1995, reportedly with some enthusiasm, but has had difficulty taking hold.

Recommendations. USAID should explore with the board of directors and the executive director of the NFPB, who were all appointed subsequent to the development of this project, their long-term vision of the role of the NFPB and the ways in which the remaining years of the FPIP can help to make that vision a viable reality. This might profitably occur in conjunction with the strategic planning and organizational development work suggested in Chapter 5.

OPTIONS II buy-in should be extended for 8-12 months (at no cost) to allow enough time for the advocacy activities to take hold. These activities should be conducted as TA activities, with full participation of the NFPB staff, who should be moving toward taking over the activities as they progress. OPTIONS II staff should be mindful of its role as a development agent and should insist on the process elements of the activity over the content. USAID should support and encourage OPTIONS II to take up this role.

3.3 Social Marketing

This component is included in Chapter 4, Private Sector, under Contraceptive Social Marketing (4.4).

1 SUSTAINABLE SERVICES

1 Public Sector: Contraceptive Supplies and Logistics (US$2,275,000)

The achievements are:

1) The Direct Distribution/Top-Up Contraceptive Logistics System has been implemented island-wide and is extremely successful.

2) Most of the Contraceptive Tracking System has been implemented in the NFPB warehouse, and staff have adequate skills to run it.

3) The NFPB phase-in schedule for contraceptive procurement is in line with USAID phase-out plans.

4) There have been no problems securing funding from the MOH for contraceptive procurement, and all but a small amount of the 1995-1996 requirement has been approved in the annual budget.

5) The NFPB is actively recruiting a logistics manager, as demonstrated by a newspaper advertisement that appeared while the team was in-country.

1 Direct Distribution/Top-Up: Contraceptive Logistics System

The Top-Up contraceptive delivery system was initiated with a pilot test of three parishes in 1992. In early 1994, two parishes were added, and in late 1994, the remaining eight were added to successfully cover the island. The NFPB logistics staff pays quarterly Top-Up visits during which they assess clinic stock levels, calculate monthly average consumption rates, and replenish stocks to their five-month requirement levels.

The NFPB provides each clinic with a calendar which indicates its own delivery schedule for the year. Future delivery dates are reviewed with clinic staff prior to the van's departure. Clarity and agreement on future delivery dates are critical for the system's successful functioning, as delivery staff must be sure they can gain access to locked stock cabinets and speak with the clinic staff. Nonavailability of clinic staff was reported to be much less of a problem now than before. On one NFPB Top-Up route visit by the evaluation team, one of the clinics was locked. Stock replenishment in this case was not possible, but efforts were made to reschedule.

According to the Project Paper, the FPIP was scheduled to receive four delivery vehicles for use in the Top-Up system. USAID/Jamaica and the NFPB report that two left-hand drive Ford Econoline Vans were procured in February 1993. The two vans are currently in good working order and are adequate for carrying out the functions of the Top-Up delivery system across the island. USAID/Jamaica plans to procure the remaining two delivery vehicles during 1996 to arrive toward the end of the FPIP. The goal will be to leave the NFPB with two new vehicles as the project comes to a close.

Conclusions. The design and implementation of the Top-Up system is highly successful and well received around the island. The system has led to a streamlined handling of contraceptives with more accountable records and accurate logistics data. The Top-Up visits have not only

resolved previously experienced stock problems, but have also created an ideal opportunity for the NFPB logistics staff to provide on-site technical assistance to clinic staff on the management of contraceptive stocks. In addition, these clinic visits provide an important channel of feedback from clinic staff to the NFPB regarding issues such as the popularity of the silver wrapped (IPPF procured) condoms vs. the plain, no-logo condoms.

Recommendations. The Top-Up system should be continued and monitored on an on-going basis by the soon-to-be-hired NFPB logistics manager and warehouse staff. The logistics manager should develop a checklist of skills in which all delivery and warehouse staff are competent. The NFPB should continue its delivery schedule as planned, but to further ensure the presence of clinic staff the NFPB should liaise with the parish health departments or parish liaison officers, to engage them in communicating with individual clinics regarding next delivery dates.

Feedback received by the NFPB delivery personnel from the field should be captured in a more formalized and comprehensive way, and forwarded to the appropriate NFPB staff to enable them to respond to clients' needs.

USAID/Jamaica should proceed with the scheduled procurement of the two additional delivery vehicles as planned. The same models, Ford Econoline, should be procured, as they are adequate for the job and are easily repairable in Jamaica. It is suggested, however, that manual drive vehicles be procured to facilitate efficient and less costly vehicle repair. In addition, it is recommended that sufficient funds be made available for the ongoing maintenance and repair of all delivery vehicles.

1 CTS and Logistics Management Information Systems (LMIS)/MIS Link

It was reported that the CTS/D (daily-entry) was left in-country by a CDC consultant and that technical assistance in its use is being scheduled. Although warehouse staff appear to be adequately trained, the team observed incorrect data interpretation, which raises the question of whether staff are fully able to generate and interpret required data.

While CTS can track the stock status of all clinics, it cannot yet do this for the central warehouse. Although CTS can generate some reports, others have yet to be developed by CDC (such as the Parish Aggregate Reports).

Most of the CTS appears to be on track. There are some reports that have not yet been finalized, and apparently only some manual reports are circulated to the NFPB senior management.

There is no link between the LMIS and the MIS service statistics information system (ServStat). Despite efforts reported by OPTIONS II, the lead agency under the FPIP, to link the various components of the MIS, CDC, and FPMD, each focused on its own components initially, and a bridging program has been developed, but not yet installed by FPMD.

Despite numerous consultant and staff reports about the non-functional warehouse printer, it has not been adequately repaired, and computer-generated reports and information are not available.

Conclusions. While most of the CTS is in place and data entry is occurring on a regular basis,

the program and reports have yet to be completed by CDC to finalize the CTS design and implementation process.

Recommendations. Further technical assistance should be provided to the warehouse and senior staff on report interpretation and analysis of CTS information and reports. Once hired, the logistics manager should also receive personal training from CDC staff on CTS management and data analysis.

The warehouse printer should be repaired or replaced immediately to facilitate the printing of computer-generated reports.

Since it is widely agreed that the LMIS-MIS bridging program may be beyond the capabilities of the NFPB staff, the bridging program should be abandoned and data comparisons performed manually.

1 Separate Logistics System for Depo-Provera

Although Depo-Provera is not related to the USAID-funded FPIP, the fact that it is distributed by the NFPB brought it into the evaluation team's field of view. The following observations, therefore, are meant to draw attention to the concerns rather than to suggest responsibility for addressing them.

As a result of a serious six-month stock-out in 1992 and the NFPB's uncertainty that the GOJ will meet its commitment to provide sufficient procurement funds, it felt compelled to secure a safety net for itself by recovering costs for Depo-Provera from public sector sales. Verbal reports indicated that the NFPB has collected US$125,000–US$200,000 from the sale of this product over time. Again, while these are not USAID-related funds (since the Depo-Provera supplies were not obtained through USAID), the concerns raised about the management of deposits, the board of directors' awareness of these funds, expenditure of the funds, and general financial accountability heightened existing questions that suggest the need for a USAID audit.

The cost-recovery effort has resulted in a parallel logistics system for the distribution of Depo-Provera. In this system, the parish health departments send quantity requisitions to the NFPB and deposit their payment in the NFPB's account. Parish health departments then drive to Kingston, submit proof of deposit, and pick up the product. In addition to the requisitioned amount, the NFPB issues 40 percent free to the parishes to serve as a safety net stock for clients who cannot afford to pay. It is the parish's responsibility to distribute the Depo-Provera among its clinics, and to decide which clinics receive how many free products.

The MOH maintains usage rate information for all contraceptives, and the amount of Depo-Provera used is provided to the NFPB on a regular basis through monthly clinic reporting forms. The NFPB currently has 1.3 years' supply of Depo-Provera in its warehouse (expiration dates 1998-1999); this excess is due to a procurement of one years' stock from UNFPA along with an interim provision of supply through the World Bank.

The NFPB is currently discussing alternate means of cost recovery for Depo-Provera with Primary Health Care (MOH) and its planned integration into the Top-Up logistics system.

Conclusions. There are two concerns about the parallel distribution system for Depo-Provera: 1) This second logistics system is inefficient and creates far less reliable and accurate collection of logistics data, which handicaps forecasting efforts. 2) The amounts requisitioned by the parish health departments are based on the amount of money available in the clinics to purchase the product, not on actual monthly consumption rates or quantities estimated to satisfy product demand in a particular area. It is a concern that the desire of the NFPB to recover costs for Depo-Provera may actually serve to inhibit the expansion of the demand for this longer-term method. In the context of NFPB's policy shift towards the promotion of longer-term methods, this is of particular note and concern. Further evaluation would be required to confirm whether clinics actually have the quantities they require to meet full demand and to confirm that rationing of the product is not occurring in selected areas. As previous consultants have noted, the system as it stands may represent a barrier to effective expansion of the method.

Recommendations. As recommended previously, the NFPB should eliminate this second logistics system for Depo-Provera and integrate distribution of the product into the successful Top-Up system. Merging of these two systems should be directed by the soon-to-be-hired logistics manager in coordination with the MOH and parish health departments. If the cost-recovery efforts are to continue, a more streamlined system should be devised.

1 Separate Logistics System and Cost Recovery for Condoms Obtained for the MOH Epidemiology Unit

The NFPB procures condoms for the Epidemiology Unit of the Ministry of Health for AIDS/STD prevention and control. The Epidemiology Unit reported that from March 1993-March 1995, it paid the NFPB approximately US$28,899 for a total of 1,816,000 units. The NFPB charges for the procurement service in addition to half the cost of the condoms.

Condoms are requisitioned by the Epidemiology Unit as required, collected from the NFPB's central warehouse by Contact Investigators and distributed to the parishes during outreach efforts. The NFPB then bills the MOH. The NFPB includes condom requirements for the "STD condoms" with its family planning condom requirements.

Conclusions. This constitutes a third and segregated component of the contraceptive logistics system managed by the NFPB. Even if the MOH logistics data about the STD condoms is accurate, it is inefficient to have three separate logistics systems, and it further compromises the NFPB's ability to compile complete and accurate forecasting data.

Recommendations. A CDC consultant, in conjunction with the logistics manager, should evaluate the possibility of aggregating the condoms for the Epidemiology Unit into the Top-Up system. This evaluation should include an assessment of how usage data is currently collected, and what special requirements need to be considered by the MOH for their Contact Investigation outreach efforts.

1 The NFPB Contraceptive Procurement

A decision was made by the NFPB and USAID in conjunction with the CAs early in the project not to phase in 20 percent of contraceptive procurement per year of all contraceptives across the

board, but rather to concentrate the NFPB's initial procurement efforts on the procurement of condoms alone since their procurement was viewed to be more straightforward than other contraceptives.

The NFPB did not procure the first 20 percent requirement in the first year of the project (due to a mix-up between the GOJ, FPIP or USAID about which fiscal year to use), but in 1993 proceeded with the phase-out schedule and initiated the first condoms procurement; these were received in two shipments during 1994. This procurement was done through International Planned Parenthood Federation (IPPF)/London, which is no longer providing this service. Although it was anticipated that obtaining foreign exchange would present a difficult barrier to procurement, the NFPB reported that it was ultimately not a problem. The NFPB has not procured any percentage of the remainder of its contraceptive requirements, and a phase-in schedule has not yet been planned.

Despite the brief but encouraging history of MOH funding, the NFPB is concerned about the GOJ's long-term commitment to procuring contraceptives in increasing quantities as USAID support phases out. These concerns, in part, lead to the efforts to recover the costs of contraceptives.

At the time of the evaluation, it was unclear to the NFPB whether IPPF would meet their long-term procurement needs. IPPF reported to the team that in November 1994 it had informed the NFPB that, based on an internal management decision in July 1994, IPPF would no longer procure contraceptives for the NFPB (or anyone else other than their own clinics). IPPF believes that the NFPB should have been fully aware of this change of policy based on correspondence and phone conversations that have been exchanged since the original notification.

IPPF reported that since the NFPB had already submitted an order of condoms when this internal policy change occurred, the organization extended itself to the NFPB in two ways: 1) it offered to sell to the NFPB a portion of its requirements from the IPPF pipeline (1,296,000 units which were shipped in December 1994), and 2) IPPF offered to consolidate the remaining requirements with its own and negotiate a price and tentative shipping schedule with its Korean condom manufacturer. The understanding was, however, that the NFPB would need to finalize the pre-negotiated price and schedule, and place its own order with the Korean manufacturer.

It is not clear exactly when IPPF carried out this negotiation on the NFPB's behalf. The NFPB reports having successfully contacted the Korean manufacturer during the time of this evaluation. No firm order has yet been placed, however, and it is unclear whether the manufacturer will be able to meet the NFPB's required first delivery schedule date of July 1995. This has led to the NFPB's request that USAID send its October shipment in July 1995.

Another element in this puzzling situation is that the last CDC consultant's draft trip report (dated April 1995) demonstrates that she was working on the assumption that IPPF would continue to procure for the NFPB, indicating that she was not informed by the NFPB of IPPF's change in policy.

Conclusions. Although misunderstandings may have resulted from the communications with IPPF regarding their policy change, the NFPB did not move quickly to clarify this very important issue. The delay in contacting the Korean manufacturer and the omission of information-sharing

with the CDC consultant may be an indication that the NFPB is not fully conversant with the requirements for international procurement and the need for adequate lead time in placing large orders from foreign manufacturers.

Recommendations. A phase-in schedule for the NFPB's procurement of its remaining contraceptive products should be drafted by the NFPB with assistance from CDC and the Program for Appropriate Technology in Health (PATH). Additional technical assistance should be provided by PATH to strengthen the NFPB's procurement capability. PATH and CDC should monitor the NFPB's progress with procurement of the 60 percent condom requirements. On-going monitoring of the phase-out schedule should also be undertaken by CDC to ensure sustainability of the NFPB's procurement function.

Since the NFPB's sustainability in the area of contraceptive procurement relies heavily on the appropriation of MOH funds, the NFPB should devote efforts in its advocacy strategy towards continuous negotiations with the Minister of Health and senior government officials. Emphasis should be placed on promoting the importance of family planning in general and securing funds for contraceptive procurement to facilitate Jamaica's achievement toward its overall population and development goals.

1 Status of the NFPB Sustainability in Forecasting and Procurement

Currently, all forecasting and procurement responsibilities are handled by the deputy executive director. While no other staff contribute to these activities in any significant way, forecasts are shared with senior staff for their review and approval. The NFPB reports that it currently has the in-house capacity to do its own procurement, especially since it has already been through one condom procurement exercise. It states, however, that it continues to require technical assistance in the area of forecasting. While the NFPB says it feels confident of its procurement skills for condoms, it would require additional assistance for the procurement of oral and other contraceptives, which it has not yet had the experience of procuring.

The NFPB is not familiar with the laws and regulations regarding expenditure of GOJ funds for procurement, especially in relation to bidding and tender requirements vs. a justification mechanism allowing it to go directly to a particular supplier.

Conclusions. Despite the NFPB's assessment that it has the skills to carry out procurement on its own, the team believes that additional in-depth technical assistance is required in this area, as indicated by interviews with the NFPB staff and the staff of CAs.

It is unclear whether the NFPB's difficulties in carrying out accurate forecasting and procurement are due to the absence of qualified staff to learn the skills, or to TA that has focused on doing the work rather than teaching the skills.

Recommendations. The CAs, USAID/Jamaica, and the NFPB should assess whether the NFPB will realistically be able to proceed with its own forecasting and procurement, assuming that it receives additional and focused TA in these areas. They should also assess the ability and preparedness of the newly established Health Corporation Ltd. (HCL). A statutory board of the MOH, charged with the responsibility of procuring health-related commodities, to procure

contraceptives for the public sector.

If it is determined that the NFPB will handle its own forecasting and procurement, appropriate and intensive technical assistance should be provided to the soon-to-be-hired logistics manager, the NFPB senior staff, and the warehouse and distribution staff. This TA should be in-country, and should be custom-designed to focus on the NFPB's particular needs of forecasting and procurement. In order to ensure transfer of skills, this assistance should be hands-on training, and the activities themselves should be carried out by the NFPB staff under the guidance of the consultants. It is essential that both sides resist the temptation of having the CAs carry out the work for the NFPB.

1 Logistics Manager

There has been a long delay in filling the logistics manager position due to difficulties in obtaining approval from the Ministry of Public Service, and other problems related to the job description. It has also been difficult for the NFPB to fully accept the need for this position, partly because it requires that senior staff relinquish parts of their current roles and associated control over various aspects of the logistics system.

Recommendations. As has been recommended and discussed repeatedly in the past, in order for the NFPB to be successfully sustainable in maintaining its contraceptive forecasting, procurement and logistics management role, it is imperative that a senior level logistics manager be hired and granted the full responsibility and authority to handle these duties. Without this manager in place, the logistics activities will continue to be fragmented and inefficient. While the logistics manager will report to the deputy executive director, this individual will need to be fully authorized to oversee and manage the NFPB's forecasting, procurement, and logistics activities. It is clear that unless this level of responsibility and authority is granted to the logistics manager, this individual will not have the tools to properly manage and oversee logistics activities in the long term.

There should be a logistics staff consisting of individuals capable of participating in the areas of logistics, forecasting, and procurement, a delivery team for the Top-Up system, and a staff for data management and analysis. The logistics manager should be provided with full and detailed training by CAs in all aspects of procurement, forecasting, and logistics management in Jamaica. Training should be hands-on, and should be specific to the local context. The logistics manager should participate in the John Snow, Inc./FPLM logistics management course in Washington, DC, as well as any other training ventures recommended by John Snow and/or CDC.

It is strongly recommended that this position be filled by July 1995.

1 Public sector: Family Life Education (Project Agreement US$250,000, Subproject Document US$510,000)

The institutionalization of family life education (FLE) in the national school system, through the Ministry of Education and Culture (MOEC), is an important component of the sustainability objectives of the present Project. It aims to instill family planning awareness and information in the younger generation. Although the NFPB has statutory responsibility for such education,

MOEC controls the ability of the NFPB to implement that mandate. ("Analysis of the Legal and Regulatory Environment for Family Planning in Jamaica," January 1995).

The achievements are:

1) In November 1994, GOJ met the Conditions Precedent for the funding of the FLE component of the project.

2) A subproject proposal, specifying the major program activities for FLE, was prepared in January 1995 by an inter-agency committee including MOEC and the NFPB, with TA from OPTIONS II.

3) The subproject proposal has been finalized and is currently awaiting official MOEC authorization. Arrangements are underway to begin this activity as soon as possible.

1 Findings

The implementation of this FLE component of the project was delayed until the Conditions Precedent required by USAID were met. The conditionality of this component resulted from an analysis of lessons learned from USAID's previous experience in financing a FLE project under the previous bilateral agreement.

The policies and activities required from MOEC to qualify for project support were as follows:

- Actively integrate the subject of FLE into the curriculum, especially for primary and all-age schools, and institutionalize it as an examinable subject;

- To formalize FLE as a subject in teachers' colleges, making it compulsory and examinable;

- To revise the methodology for communicating family planning and birth control concepts and messages in the FLE curriculum.

The activation of this component has required careful and supportive efforts from USAID/Jamaica and the NFPB, with TA from OPTIONS II and from local consultants:

1) A "Situation Analysis on FLE in Jamaica and Statement of Policy Issues" was commissioned by USAID/Jamaica (April 1994).

2) MOEC, with the support of the above document, prepared a policy submission for approval by the GOJ Cabinet (November 1994). This policy document contains a stated goal of ensuring a more systematic and effective development and implementation of FLE, through institutionalizing the mechanisms to support this activity. These include training of personnel, development of appropriate resource materials, and hiring of specialist teachers if necessary. The document also proposes a FLE inter-agency committee for advisory purposes, chaired by the NFPB.

3) GOJ Cabinet approved the policy (November 1994). Even before Cabinet approval,

however, MOEC indicated that it had the authority to institutionalize FLE and that it intended to move ahead with a strong program. At this stage USAID/Jamaica determined that the conditionalities as outlined in the Project Agreement were adequately satisfied (PIL 32, November 3, 1994).

The current subproject proposal (January 1995) outlines six major activities:

1) Baseline research and impact evaluation, to assess what is currently taking place in the school system.

2) Curriculum development, through three three-day residential workshops, to review, revise, and finalize grade-specific curricula.

3) Development and mass production of new materials, again through three three-day workshops, followed by contracting out the task of mass production.

4) Development of preservice and in-service training of FLE teaching personnel.

5) Implementation of the new curriculum in 100 selected primary and all-age schools.

6) Advocacy activities directed toward school administrators, education leaders, parent-teacher associations, and others.

A finalized version of this document currently is awaiting MOEC approval for implementation.

Concerted efforts to develop the FLE component are just now beginning to come to fruition. For the present, the infusion method will continue in primary and all-age schools, rather than FLE being institutionalized as a separate and examinable subject as originally required in the Conditions Precedent. USAID/Jamaica and MOEC jointly agreed that it was not currently feasible to implement the conditionality as originally stated (PIL 32). However, MOEC states that it is committed to improving the quality and focus of the infusion method at these levels. Subproject activities are focused on strengthening and unifying the curriculum at these levels.

The subproject also proposes stronger training programs for FLE teachers, both preservice (teacher training colleges) and in-service.

At the secondary level, specialist FLE teaching will be linked with the Reform of Secondary Education (ROSE) program, which is intended to ensure that a strong and good quality secondary curriculum is available to children in all types of secondary schools.
Conclusions. This activity has suffered from MOEC delays in meeting the Conditions Precedent, and the program is off to a slow start, since assessment of the current school situation is deemed necessary before curriculum development and production of materials can begin.

The quality and focus of the infusion method is critical for the improved success of this program.

Recommendations. Every effort should be made by the project coordinator to encourage speedy implementation, especially of the preparation and mass production of teaching materials, which will require adequate lead time.

Efforts should be made to undertake some activities concurrently. For example, activity (6) should be planned to take place throughout the project. Again, if curriculum development is divided into different levels, consultations about the production of teaching materials for a given level can begin as soon as the curriculum for that level is decided upon.

1 Public Sector: Clinical Methods (US$450,000)

The intent of this activity is to assure that cost- and contraceptive-effective methods are widely available. The purpose of the component is two-fold: to establish a process by which the leadership of the family planning program can systematically look at clinical methods and method mix improvement, and to provide funding and TA to implement changes in clinical service delivery based on information generated by that process.

The achievements are:

AVSC has provided a substantial amount of training, clinical and counseling, for physicians, nurses, alternative health workers, and male motivators.

1 Findings

The Project Paper clearly identifies the medical subcommittee of the NFPB board of directors as the leadership group to address method mix and constraints to clinical methods service delivery. It recommends a new constellation of the committee and suggests permanent and *ad hoc* membership; it places the NFPB in a proactive leadership role and speaks of the need to develop a collaborative approach among the various entities to implement the policy and planning steps. In fact, the language in the Project Paper is a warning that this committee may have a difficult time working; as it happens, the committee has never been formed, with the board chairman reporting that there are enough doctors on the board of directors itself, and a subcommittee is therefore unnecessary. While it is understood that a full board of directors has not been appointed by the Minister of Health, the NFPB could have established another mechanism through which it could address these activities. That it has not is worrisome because it speaks to the difficulty the NFPB faces in shifting into the coordination and collaboration roles.

Clinical training has been provided by AVSC as follows:

- Postpartum IUD insertion and removal: three physicians, two nurses
- ML/LA: seven physicians, three physician/nurse teams, five nurses
- NSV: five physicians

Training workshops have been conducted by AVSC as follows:

- Vasectomy Information and Education (I&E) Workshop for Male Motivators: 24 participants
- NSV Medical Workshop for urologists and surgeons using scrotal models: 15 participants
- Vasectomy I&E and Counseling Workshop for Health Professionals - two males, 12 females
- Vasectomy I&E Workshop for Male Motivators - 20
- Postpartum IUD Counseling and Client Follow-up for nurses, midwives and public health nurses - 25 participants
- Training in Family Planning Counseling for Alternative Health Workers - 12 participants
- Infection Prevention Update - 21 participants

A pilot project to introduce postpartum intrauterine devices (IUD) into the existing family planning and maternity services at Victoria Jubilee Hospital (VJH) will begin in May 1995, preparatory to guiding future postpartum IUD programs, and contingent on the clinical and programmatic outcomes of the pilot. Representatives from each of 18 other sites identified as referral and follow-up sites for postpartum IUD services attended an orientation workshop to introduce them to postpartum contraception and counseling.

Conclusions. Physicians, nurses, and alternative health workers are being trained to carry out traditional and non-traditional roles in the public sector service delivery system; however, the bases on which the decisions are made to provide the training and TA are not related to a rational NFPB process of systematically looking at clinical methods and method mix improvement. While the studies to determine an ideal method mix have been completed, the NFPB and MOH must reach consensus about realistic and appropriate targets. Until that occurs, training and TA for clinical and paramedical personnel are based on a perception of needs, not on information. While it is not impossible that this method of relying on perception works, it leaves the NFPB vulnerable to the movement of individuals who have the personal skill to spin off fairly accurate forecasts based on historical information. It will be helpful to have a more systematic process in place.

Recommendations. The NFPB should pursue the MOH to reach consensus on the targets for the ideal method mix over the next 5-10 years. Once completed, the information should be used to inform the number and background of people trained, and the topics in which they are trained. The information should be considered in the forecasting of contraceptive needs so that the NFPB can actively support the shift from short-term to long-term methods.

1 Private Sector: Contraceptive Social Marketing (US$1,320,000)

As a key component of the FPIP five-year strategic plan to shift contraceptive usage from short- to long-term methods, and to shift some of the burden of service delivery from the public to the private sector, the NFPB embarked on the Personal Choice social marketing program. The emphasis of this program is to engage contraceptive pharmaceutical companies, pharmacies and private doctors to market services and products which are affordable and accessible to middle- and lower-income consumers.

The achievements are:

1. In 1993 the NFPB met the Conditions Precedent set by USAID to divest the Commercial Distribution of Contraceptives Program in order to initiate the Personal Choice social marketing program. This marks a significant policy reform that had been in process for a few years.

2. SOMARC has successfully negotiated letters of agreement with five distributors: Medigrace (Perle LD), H.D. Hopwood (Depo-Provera), Lasco (Minigynon), Schering (Minigynon) and Carimed (Minigynon).

3. The Personal Choice media campaign, begun in late April 1995, is working toward improvement of the reputation and image of Depo-Provera as a "poor woman's contraceptive method."

4. Training, trade promotion strategies, market research, media campaigns, and public relations activities have all begun under SOMARC's leadership.

1 Divestment of Commercial Distribution of Contraceptives and the NFPB's Response to the Start-Up of the Personal Choice Program

Conflicting reports by senior staff of the NFPB made it difficult to ascertain precisely how much money has been deposited and invested over time from the sale of the Commercial Distribution of Contraceptives. The "Status of Commercial Distribution of Contraceptives Balances as of March 1995" reports that the NFPB has approximately US$325,000 (J$10,400,000) in investments from this sale.

In November 1994 the NFPB received US$29,635.20 from the sale of 100,800 cycles of Noriday, which were provided by USAID to be sold to Medigrace. Although, according to USAID/Jamaica, the NFPB has indicated receipt of this money, the funds are not reflected in any financial statements reviewed by the team.

Recommendations. USAID should conduct an audit of the Commercial Distribution of Contraceptives funds and the income generated from the Noriday sale, and the results should be shared with the board of directors. Because USAID must approve the use of any funds from the divestment, it should work with the NFPB to develop a clear strategy for the use of the funds for contraceptive procurement and/or continued support of the Personal Choice campaign. Funds collected from cost-recovery efforts for Depo-Provera could also be considered in this strategy.

1 Reclassification of Oral Contraceptives

A major barrier to brand-specific mass media campaigns for low-dose oral contraceptives has been the product's current classification as a List Four pharmaceutical product-- that is one which requires a prescription. An appeal was made to the Pharmaceutical Services Division of the MOH to lift this restrictive classification so that brand-specific advertising can be conducted for an easily accessible product.

Recommendations. The NFPB, in conjunction with SOMARC, should direct strong advocacy efforts toward the successful reclassification of oral contraceptives so they can be formally dispensed over the counter without a prescription. In preparation for reclassification, the Personal Choice program should emphasize its training programs for pharmacists and pharmacy attendants to ensure proper and adequate counseling of clients.

1 Work with Distributors

Each of the letters of agreement outlines each party's responsibilities regarding the maintenance of reduced product prices and advertising campaigns. In addition, the manufacturers have agreed to provide 5 percent of their annual sales as an in-kind donation to the NFPB for use as promotional samples in detailing and training efforts.

Distributors are required to provide sales data on a quarterly basis as part of their agreements. This data are to be collected by SOMARC, summarized, analyzed, and shared with all the distributors and the NFPB. SOMARC also holds quarterly meetings with all distributors to facilitate the exchange of information and to present the status of the Personal Choice program.

Both Medigrace and H.D. Hopwood are satisfied with the Personal Choice program and anticipate increased market sales volumes as a result of their concession of reduced product prices. Both report being pleased with the Personal Choice training efforts for private physicians, nurses, pharmacists and pharmacy attendants and consider that increased information and counseling skills will be beneficial not only to their sales, but to the overall reputation of their products and improved quality of pharmacy-based service delivery.

The local distributors have indicated that they do not think a year was sufficient marketing time to evaluate whether or not reduced prices could yield increased market volume sales on a long-term basis. They reported that if the strategy continues to yield higher volume sales, they are committed to maintaining reduced prices. In particular, since the media campaign for Depo-Provera started at the end of April 1995, the H.D. Hopwood representative voiced her concern regarding the scheduled end date of the Personal Choice program and reported that achievements would be extremely limited if the advertising campaigns were to be cut off in September 1995.

Recommendations. It is essential that the distributors gain the benefits of the program in order that they may be convinced of its long-term business viability. Significant additional funding should be provided for the SOMARC project to continue its activities, and a one-year extension of the buy-in should be granted by USAID.

1 Social Marketing vs. Cost Recovery

The H.D. Hopwood representative and SOMARC report that the Personal Choice program is experiencing market competition by the NFPB against its own social marketing venture. H.D. Hopwood described its experience of trying to market Depo-Provera to private physicians who respond that they already have sufficient and less expensive stocks from supplies purchased directly from the NFPB. It appears that by pursuing its cost-recovery efforts for Depo-Provera, the NFPB may have been jeopardizing its own social marketing goals and overall FPIP policy objectives of a shift of long-term methods from the public to the private sector.

Discussions with the NFPB led to its reassessing the situation of potential competition, and the executive director has issued a directive to stop the sale of Depo-Provera to private physicians. The NFPB does not anticipate any further potential areas of competition with the Personal Choice program.

Recommendations. SOMARC, the NFPB, and USAID/Jamaica should reassess the NFPB's social marketing strategy in relation to its cost recovery efforts to determine whether the cost-recovery strategy should be altered to be more effectively integrated with the FPIP's social marketing objectives, or whether the social marketing strategy should be adjusted to function more effectively in the environment of cost-recovery activities.

1 Personal Choice and Long-Term Methods

Depo-Provera - The media campaign, begun in late April 1995, focuses media and educational attention on the benefits, convenience, and discretion the method can afford women of all social classes. Work has been done by SOMARC in conjunction with the distributor and a local advertising agency.

IUD - The Personal Choice program is eager to include the CuT 380A IUD in its program, and a contract with Finishing Enterprises is currently under negotiation. Although there is a market niche for IUDs, there is strong provider and client bias against use of this method at the present time. (See Consumer Attitudes and Behaviors Regarding Contraceptive Methods in Jamaica, Final Report, January 1994; Service Delivery Practices of Private Physicians in Jamaica, May 1994.) Once an agreement is reached, the Personal Choice program will explore the most effective education and training campaign to work in the Jamaican context.

Voluntary Surgical Contraception (VSC) - The Personal Choice program has had to scale down its ambitious targets for NSV due to cultural bias in Jamaica. The program has not embarked upon any mass media campaigns for this method, but has attempted to increase awareness through education, trainings, and public relations activities. AVSC has provided support for the awareness campaigns by reviewing informational pamphlets and news releases for technical accuracy. SOMARC's goal is to raise the level of general public awareness about NSV despite the fact that it is working in a context of deeply ingrained myths which are difficult to dispel. VSC is popular among women, although there are some fears and concerns associated with it which can be addressed by media attention to the issue. The major problem that accounts for the slight decrease in VSC noted in the CPS is the lack of trained providers at strategic points around the island.

1 Program Activities

Training: Most of the Personal Choice training objectives have been met by SOMARC; they have been successful and well received. They have included a pharmacist training of trainers course (TOT) on contraceptive technology, customer service, management and counseling skills. Further training has been undertaken through participation in seminars by the Medical Association of Jamaica (MAJ), American College of Obstetrics and Gynecology (AGOG), and the Association of General Practitioners (AGP).

Trade Promotion Strategies: After an evaluation of what physicians and pharmacists could most use, the Personal Choice program has chosen to provide prescription pads for dispensing doctors and pill counters for participating pharmacists. No financial incentives are extended to providers by the program.

Market Research: In addition to OPTIONS II focus group research in 1993, further market research was completed by SOMARC in early 1994 to assess cultural practices, attitudes, and knowledge about contraceptive methods in Jamaica. Data collected were used to inform the advertising briefs for mass media campaigns. All advertisements were pilot tested in a number of focus groups (of women ages 18-44), and results indicated that advertisements were appropriately focused prior to public launch. After initial runs, SOMARC has fine-tuned its advertisement messages into their final comprehensive media campaigns.

Media Campaigns: The Personal Choice program has met with an excellent response to its aggressive and intense media campaign. Represented by its Personal Choice logo, the program has unified a family of high quality and affordable contraceptives for promotion to the private sector. Media ventures have been explored through radio, television, and in print advertisements, and have been instrumental in the program taking on a life of its own.

Public Relations: Much successful public relations work has been completed jointly by SOMARC and the NFPB, with extensive activities being pursued directly prior to and after product launches. The executive director of the NFPB has pursued many successful speaking engagements with the press and has fielded difficult questions regarding the NFPB's objectives and the Personal Choice program with ease and political savvy. The program has trained speakers on how to work with the media, particularly regarding how to discuss difficult topics such as vasectomy and condom use among young adults. The budget for public relations activities is approximately US$63,000; this does not include media advertising costs.

1 Continuation of the Personal Choice Social Marketing Program

The social marketing component of the FPIP started late due to the Conditions Precedent of CDC divestment and USAID contracting administration. Once it began, the program spent its first year laying the groundwork with local distributors and developing advertising materials. The electronic media campaigns and product launches have occurred in the program's second year. All advertising is done through a competitively selected local agent, Dunlop, Corbin & Compton.

The Personal Choice program is scheduled to end in September 1995. Of note was the NFPB's report that they were not aware of the end date until February 1995, despite the fact that they

had signed off on the project implementation order (PIO/T) funding mechanism. The NFPB reports that it has not explored alternate funds to continue advertising campaigns, nor does it have concrete plans to pursue the program when SOMARC's funding ends.

Conclusions. The team is particularly concerned about the scheduled end date, since successful marketing activities are just getting off the ground as the program heads toward its last five months of funding. SOMARC, the NFPB, and local distributors all share this concern and belief that the Personal Choice program should be extended. One year (and in the case of some products much less) is not sufficient time to promote significant behavior change and to convince distributors that they will benefit from increased volume sales in the long term by maintaining reduced prices.

Recommendations. SOMARC's funding should be extended for at least another year and granted significant additional funding to further explore anticipated successes of increased market volume sales through distributor-reduced prices. With continuation, the NFPB through SOMARC should express a firm commitment toward highlighting long-term methods through media campaigns and public relations activities. Emphasis should also be given to continued training efforts and the completion of a reference handbook for nurses and pharmacy attendants.

1 Private Sector: Private Providers (US$382,000)

This activity, which is just getting under way, is designed to encourage the participation of private providers in education, referral, and delivery of family planning services through the use of public relations, mass media, and training. Specifically, the Project Paper refers to physicians being offered training in family planning methods (both counseling and clinical methods application) and IEC materials for use in their private offices.

The achievements are:

Physicians, nurses, and pharmacists have begun to receive education and training about contraceptive methods in conjunction with the Clinical Methods sector of the FPIP.

1 Findings

Attempts were made to engage with FAMPLAN, the IPPF affiliate, but they reportedly submitted several unacceptable proposals and ultimately withdrew from the process, believing that they lacked sufficient infrastructure to undertake the project. OPTIONS II subcontracted with the UWI/FMU/ISER to undertake the Mapping Study and Private Physicians Survey in order to support the pilot project with Private Providers. OPTIONS II provided TA to the NFPB to jointly design the pilot project. USAID/Jamaica and the NFPB issued competitive bids to Jamaican organizations, and a consortium led by T. Hamilton won the bid. The strategy for this activity is to conduct a pilot project in two areas with little public sector presence, supporting private physicians to participate in half-day sensitization seminars where they will receive family planning information and share a database for reporting their services. The seminars, the first step in the clinical training program for physicians, nurses, and pharmacists, are scheduled to begin in May 1995, and it is hoped that this project will link with the Continuing Education Seminars run by the MAJ in association with FHI.

The impact of this pilot project will be studied at its completion in October 1996, with the expectation that if it is successful, it may be expanded to other areas.

In a project that is complementary to FPIP, FHI has contracted with MAJ, and collaboratively they have created a series of Continuing Education Seminars to run over two years. The seminars will be held at three sites on specified weekends, and will feature several local speakers and a well-known international speaker. The NFPB medical director was hired to be the technical advisor to the MAJ to ensure that the local speakers will provide information that is consistent and accurate. The first weekend meetings were held during the evaluation with attendance beyond what was expected and a very successful launch.

1 Private Sector: The Women's Center (US$250,000)

The Women's Center received a small grant of US$250,000 under the AVSC buy-in to work with young women to delay their first pregnancy. Founded in 1978, the Women's Center has had a successful track record in helping young women under 16 return to school after their first pregnancy. They have achieved a 1.1-1.4 percent rate of second pregnancies among young women who are in school, enabling them to continue until they have reached their educational or vocational goals. There are three aspects to the new project:

1) The Grade 7 program, in which counselors go into the secondary schools to teach family life education (FLE), family planning, and provide a lot of counseling to boys and girls who have not been accepted into high school, and who are considered potentially at risk for early sexual activity based on their feelings of failure and inadequacy.

2) The homework program, in which 9-13 year-olds are provided with a safe, educationally-oriented after-school program four evenings per week, and one evening of counseling, family planning, and FLE. Parents receive counseling one evening per month.

3) The KEY program (Knowledge and Education for Youth) is a walk-in women's health clinic and counseling center for boys and girls. Counselors conduct group sessions for up to 30 students who have the opportunity to talk about a broad variety of subjects, stop in for individual counseling or health care from two volunteer physicians, and receive referral and escort for family planning services.

This project has been under way since January 1994, with some aspects of it taking place only in Kingston (KEY), others in three other main sites and 13 outreach areas. The Grade 7 program has served 2,609 students island-wide; the homework program has served 214 9-13 year-olds; the KEY has seen 646 clients, made 110 referrals, trained 248 peer counselors, and made 46 home visits.

In collaboration with AVSC, FHI is conducting a prospective study of the program with funding from its Women's Studies Cooperative Agreement (not part of FPIP), and will look at the Grade 7 and KEY programs to ascertain their impact on self-esteem, decision-making skills, sexual activity, and family planning use or nonuse. The study is expected to provide information that can be used to improve training and performance of counselors and educators in a pregnancy-

prevention program; modify this project and inform the development of similar projects; inform service providers, policy-makers and funding organizations about adolescent sexual behavior and decision-making processes; assess the effectiveness of limited duration classroom sessions in delaying sexual activity through improved self-esteem and decision-making skills; and better understand the role of family planning in the lives of adolescents. The study is scheduled to begin shortly.

The Women's Center reports an easy and collaborative relationship with AVSC.

Recommendations. This outstanding program, whose outcomes have been demonstrably positive, should be used as a model for adolescent outreach, and if the FHI evaluation shows it to be as successful in its efforts at pregnancy prevention through education as previous evaluations have shown it to be, further funding should be directed to the Women's Center to expand its preventive and other programs.

1 INSTITUTIONAL STRENGTHENING OF THE NFPB (US$585,000)

The main activities planned for this component of the project were:

1) The institutional development of the NFPB, including strategic and marketing plans

2) The Management Information System

3) The staff training to equip the NFPB to assume new responsibilities for a vigorous and dynamic family planning program

1 Strategic Planning and Advocacy Roles

"The issues of sustainable financing, private sector involvement, policy analysis, and marketing are new areas to be addressed by NFPB. Assistance ... is designed to facilitate the shift in primary focus from implementation of subprojects, to advocacy on population and family planning issues, and coordination of the national FP program...NFPB must recruit new staff and develop existing staff who are capable of planning, managing, and evaluating a different sort of FP program, and carrying out a very different role for NFPB itself ..." (Project Document, p. 21)

"To successfully implement the initiatives planned .. NFPB will require an active visible presence advocating the allocation of substantial resources and attention to family planning needs...[and] creative, innovative leadership in the coordination of nationwide service delivery activities...Responsibility for implementation activities serves to divert NFPB attention and resources from its critically important advocacy/leadership role, for which no other Jamaican organization can successfully substitute." (Project Document, p. 22)

These statements underline the need for the NFPB to engage in strategic planning for its internal development and its role as a leader of the family planning program as it looks to its future.

The achievements are:

1. Technical assistance provided under the OPTIONS II project has provided a substantial body of analytical documentation on family planning in Jamaica, for use in strategic planning and in orienting the NFPB to its most effective roles. There has been a virtual deluge of strategic information, and the NFPB has been reasonably effective in grasping it.

2. Development of a five-year strategic plan, through a participatory series of meetings in late 1992, resulted in the Strategic Plan, 1993-1998. Out of the Strategic Plan, a Monthly Work Plan was later developed, March 1994-April 1995.

3. In relation to the management of FPIP, an internal management review for the NFPB, USAID, and OPTIONS II was held in December 1993, and a planning meeting of all Cooperating Agencies, as well as the NFPB and USAID, was held in February 1994. As a result of that planning meeting, the one-year Monthly Work Plan, March 1994–April 1995, and a wall calendar listing tentative CA travel schedules, were developed.

4. A three-day Advocacy Strategy Workshop was held by the NFPB in January 1995, and an Advocacy Strategy Document was produced, identifying necessary action to be taken by the NFPB.

5. As an outcome of the Advocacy Strategy Workshop, work has begun and is near completion on a brochure describing the mission and objectives of the NFPB, and a policy booklet, *Family Planning as a Tool for National Development.* These publications will expand public recognition of the role of the NFPB and the importance of population issues for development.

1 Findings

1. The NFPB, a fairly small agency with settled traditional family planning activities, has found itself faced in the 1990's with fundamental changes in its modes of operation and with substantial demands for assimilation of new data, responsiveness to change, and strategic planning.

2. The fundamental changes called for by the project have not been easy to achieve. Some crucial factors have been the appointment of a new executive director in January 1992, after the project had already been approved; a slow adjustment of the NFPB to unfamiliar role demands; a staff reduction exercise necessitated by GOJ public sector reductions, which mainly removed junior posts but did not facilitate major staff renewals; and the loss of familiar functions as a result of USAID's 1991 decertification of the NFPB due to employee fraud in the previous project.

3. In spite of the above, systematic activities towards the strategic planning and advocacy roles have been effectively undertaken by the NFPB, with TA from Options II.

4. Not enough attention has been paid to the basic managerial systems of the NFPB which are not well adapted to handling the sophisticated demands of new strategic plans and new advocacy roles. The following demonstrate this:

    - Authority is centralized and not adequately delegated. On the other hand, there is not enough supervision and guidance of junior staff.

    - Organizational information-sharing systems are not always effective; many respondents in this evaluation claimed that they did not receive vital information. Particular examples were reported by MOH field staff in relation to the introduction of the Personal Choice program, and by the NFPB staff in relation to circulation of information within the organization.

    - Of the approximately 100 activities listed in the 1994-1995 Work Plan, only six were included under "Institutional Strengthening" (excluding MIS activities). Further, most of the activities listed were the training activities outlined above, including some which were postponed for the current year. This suggests the need for more attention to internal strengthening of the NFPB. Organizational

Development work was not built into any of the CA buy-ins, but was meant to be provided by a local source with funds directly available from the FPIP training component. While this work is desperately needed, it has been in the planning process for a very long time, and it is not clear when it will happen.

1. The difficulties of the Accounting Division of the NFPB also reveal management deficiencies. The NFPB has not moved persistently to improve its internal control procedures and thus regain USAID certification, although USAID has, over several months, reviewed with the NFPB the possibilities of its qualifying for recertification.

2. The buy-in of six CAs, each with its own staff and consultants, as well as local consultants, has created additional tasks for the organization as a whole. Additional responsibilities include: coordination tasks; numerous meetings; increased public interest and enquiries to the NFPB's public information services (Marge Roper and others) as a result of the Personal Choice campaign; organizational arrangements for seminars, workshops, and training programs. This increased demand on the available staff and on organizational management capabilities has been difficult to satisfy.

3. The use of many consultants for TA also contains an element of disempowerment for the NFPB staff. Many activities have been contracted out in a manner which did not allow the NFPB staff to offer their own expertise. This view was expressed in relation to external public relations firms, in relation to the undertaking of the CPS, and also in relation to other research. Some NFPB staff have been reduced to spectators and/or beneficiaries of TA, rather than participants.

4. Activities of CAs at the NFPB in general appear to have been based on a participatory approach. In the face of the circumstances outlined above, however, and the pressures on agencies working under contract and required to show timely results, it is generally acknowledged that the CAs have had to undertake many initiatives without an equal amount of counterpart activity, and that the transfer of knowledge and skills has been less than ideal. The roles of the CAs have not always been clear to the NFPB, which could reasonably question whether the CAs are intended to undertake technical tasks for the NFPB, or to impart and transfer technical skills.

5. An important achievement, through strategic planning, has been the divestment of the former social marketing program and its complete transfer to the private sector. However, this transfer has aligned the NFPB's image with the up-market Personal Choice program, while the NFPB's image as the universal promoter of family planning, especially for the poor, may be in danger of being lost. It is important that the NFPB reassure the lower income groups that it is still firmly on their side, and that it has not abandoned them in the name of cost recovery.

6. While the chairman of the board is notably active, the board of directors is incomplete (there are four vacancies on the 12-member board) and the urgently needed subcommittees of the board of directors (particularly the finance, medical, and publicity committees) have not been constituted, nor have their portfolios been delegated to alternative structures.

Conclusions. Faced with major shifts of focus and function, the NFPB, in the space of slightly over three years, has made a praiseworthy beginning. But the organization needs to improve its capabilities and its morale if it is to achieve the changes envisioned by the project.

Recommendations. The NFPB should recapture its advocacy role for the less prosperous groups in society through careful collaboration with MOH service delivery, especially in relation to "safety net" programs. The parish liaison officers should also be encouraged and supported in their efforts to recapture this role.

Basic management training, and training in staff supervision, should be offered as a prerequisite for institutional strengthening.

Work loads should be evaluated in view of new and unforeseen tasks arising from the multiplicity of activities. Redeployment of staff, temporary shifts, or new hirings may be needed. USAID should engage in discussions with the Minister of Health and the MOH to support the efforts of the NFPB to reorganize itself.

In relation to internal management controls, training activities and decision-making should involve more individuals in each sector. Activities and decisions which rely too much on specific individuals are undesirable from the point of view of internal control. Strong consultative committees of the board of directors in the areas of medical, finance, and publicity functions would also be very useful.

A longer period of time must be allocated to achieve strategic plans and advocacy activities, since there is a need for a basic foundation of skills and information on which to build these activities. The time frame of Options II activities should be expanded with a no-cost extension of the buy-in for 8-12 months.

1 Management Information Systems (US$230,000)

In planning sustainability for the NFPB, the development of a MIS was included to monitor the flow of services and the achievement of quantitative goals; to support forecasting of commodity needs, procurement, and distribution; and to support administrative decision-making and strategic planning. The MIS was viewed as particularly important in strengthening the responsiveness and dynamism of the NFPB in its major new roles of coordination and advocacy. Financial management and reporting ability also became issues of concern at the time FPIP was implemented, and attention was therefore focused on the financial information system.

In 1992, the Management Sciences for Health Project (MSH), under its FPMD project, undertook a buy-in to provide technical assistance in MIS. In the meantime, CDC implemented a Logistics Management Information System to monitor commodities distribution.

The main proposed activities of FPMD were a needs assessment, followed by development of a computerized service statistics information system (ServStat), MIS training for the NFPB upper- and middle-level managers, development of a computerized accounting and financial management system, development of a project activities tracking system, and design of an Executive Information System (EIS).

The achievements are:

1. Two additional computers have been acquired and installed, following the specifications provided by FPMD.

2. The ServStat software is installed and functioning.

3. Computerization of the finance and accounting system has moved slowly, but it is moving.

4. An introductory MIS training workshop was held for the NFPB staff in October/November 1993.

1 Findings

The preliminary needs assessment was carried out in January 1993, and consultations were held with CDC and MOH (which supplied the service statistics), as well as with the NFPB personnel. Later outcomes suggest, however, that the format of the needs assessment may not have garnered enough information from the NFPB. The FPMD needs assessment did not adequately uncover the lack of skills among the staff who were required to run the MIS system, nor the needs for basic management competencies before an advanced MIS could be effectively used.

Timeliness: The Project Grant Agreement required a strategic plan to be developed before TA in MIS could begin. The lead time of eleven months from the start-up of project activities to the strategic planning meetings in November 1992 and the production of a strategic plan in December 1992 represented reasonably adequate progress, given the adjustments required from the NFPB. The conduct of the FPMD needs assessment in January-February 1993, some six weeks after the strategic plan was prepared, was prompt.

The focus of MIS activities conformed to the specifications of the Project Grant Agreement. The MIS component also was expected to cover acquisition of computer equipment, systems design, and training, and FPMD also was required to assist in the computerization of the financial information system. The focus of the MIS activities, however, demanded skills and management capabilities which were not in place. As a result, up to the present, few of the tasks undertaken under this agreement have been fully achieved.

The limited skills and heavy dependence of the Accounting Division on consultants have led FPMD to recommend a locally provided, in-house computer training program for the accounting staff, and a local consultant to assist in implementing the Accounting Procedures Manual. To date, minor hindrances have obstructed the finalization of these arrangements, and it has now been decided to await the appointment of a new director of finance before implementing such a program. In the meantime, the FPMD buy-in is coming to the end of its available time and available financing.

After completing an audit in 1992, Ernst & Young provided a comprehensive Accounting Procedures Manual for the NFPB. FPMD's computerization of the accounting system was dependent on the implementation of this manual and the attainment of a smoothly running

Accounting Division, which delayed the work of FPMD and was also probably an unattainable goal. To date, the procedures of the Ernst & Young manual still have not been fully implemented. However, Ernst & Young had identified the computerization of the payroll system as an important and relatively easily implementable step for improvement of the NFPB's financial management. With the assistance of the FPMD consultant, a commercial payroll software package was purchased in September 1994. Efforts have been made to do trial runs with this payroll software with fairly good success. Familiarization with the Chart of Accounts (included in the Procedures Manual) is also taking place. The main drawbacks are the limited skills and confidence of the staff, and a heavy dependence on the input of the FPMD consultant.

Conclusions.

1. The MIS component of FPIP is a valuable opportunity for the NFPB to improve its monitoring and management capabilities; computerization must continue to be an important goal. But the computerization opportunity came to an organization which is currently unable to grasp the opportunity:

   a) Only a few members of staff have adequate computer competence, and others have not improved their skills by practice or through informal in-house supervision.

   b) More organizational development is necessary before the MIS can be assimilated 0and used.

2. The relationship between the NFPB and its technical consultants has many facets. Each consultant has a "learning curve" in relation to the organization, and when that consultant is replaced by another, some of that familiarity has to be relearned. Different approaches by different consultants are also difficult for the NFPB's adaptation. Consultants who are seen to dismantle the work of a previous consultant or who require learners to start afresh create insecurity and demoralization in the organization. Finally, due to preferences for some consultants and bonding to consultants, staff members experience feelings of loss if the consultant is unexpectedly replaced (in some cases without warning or explanation).

3. The role of technical consultants has been stated to be not always clear to the NFPB staff. There is a continuing debate as to whether they are undertaking specific tasks for the organization or whether they are training the NFPB staff to undertake these tasks.

4. The CDC style of work planning around the installation of LMIS appears to have been more effective than the approach of FPMD.

   The computerization efforts of FPMD cannot be abandoned in mid-stream, however. It is particularly important to complete work with the finance and Accounting Division.

Recommendations. FPMD should carefully configure its remaining time and finances in order to complete some of its activities. The pending consultant visit should be postponed so as to review options and determine priorities. Completion of the work with the accounting division will be more useful than a hasty attempt to bring on the EIS.

In spite of the difficulties suffered by the FPMD project, USAID should grant an extension of time and financial resources so that some of the useful activities begun by FPMD can be completed. These should be carefully and collaboratively planned by the NFPB, USAID, and FPMD.

For the purpose of sustainability, there should be cross-training of all, or as many, persons as possible in a given department. This was proposed by Ernst & Young for accountancy skills for all workers in the accounting division, and it should equally be applied to computer skills.

Systematic and long-range local training in computer skills, especially for workers in statistics and finance, should also be instituted. Hands-on coaching and practice of computer skills should be provided to the appropriate staff.

1 The NFPB Training (US$100,000)

Training for the NFPB staff was intended to develop the organization's capabilities to plan and manage new initiatives in family planning. Some of the areas outlined in the Project Agreement included market research, marketing, cost recovery, private sector development, strategic planning, and other areas relevant to the new approaches of the program. The divestment of Contraceptive Social Marketing may have reduced the need for some of the above areas of training.

The achievements are:

Individual training programs have been awarded to five staff members.

Five individuals have been supported for attendance on study tours and international conferences.

1 Findings

Additional consultations are underway between USAID/Jamaica and the NFPB as to the most productive and relevant use of training resources. The Training Plan submitted by the NFPB was acknowledged by PIL 34, March 10, 1995; but in relation to accounting staff it was agreed that local training for such staff would be deferred until training was completed under the FPMD project. It is proposed that on completion of the FPMD training, an assessment will be made as to the additional training required. Other proposals in the Training Plan are under review to determine their relevance to the objectives of FPIP.

A Target Model and DEMPROJ model workshop was held in 1994 by OPTIONS II for personnel from the NFPB, Planning Institute of Jamaica (PIOJ), and Statistical Institute of Jamaica (STATIN). Additional hands-on training on the two models and their underlying analytical methodologies were provided in March 1995.

The organizational development exercise, which has been in the planning stages for some time, has not yet occurred, and there are many issues internal to the NFPB that continue to need to be addressed. Among these is the support available from the Minister of Health to make the organizational changes that would allow this statutory board to carry out its emerging role.

Conclusions. The original priorities for training as set out in the Project Agreement require modification in view of developments since 1992.

The planning of training has not been given enough in-depth priority, given the crucial role which training could play in the institutional strengthening of the NFPB and in helping it to develop new activities.

Recommendations. The NFPB and USAID/Jamaica need to continue to address the planning of training in a consultative fashion. A thorough review of training needs and a reprogramming of the Training Plan is desirable.

Ongoing computer training efforts for staff in the Projects and Research Division and in the Accounting Division are particularly necessary.

USAID should urge the NFPB to frame the upcoming organization development as a strategic planning and organization development exercise, and it should include the board of directors. The event should involve an in-depth look at the mission of the NFPB by statute and by FPIP design, and the NFPB should determine how it will carry out its mission over the next 5-10 years, taking into consideration the phase-out of USAID and perhaps other donor funding, and the commitments that have or have not been made by the GOJ. On the basis of this work, the NFPB should determine how it will carry out the advocacy function and inform officials about the crucial place of population at the socioeconomic development table; how it will provide accurate and timely information for the procurement of contraceptive commodities; how it will stimulate the interest of private sector physicians in providing family planning clinical methods; and how it will reach out to adolescents, whose choice to use appropriate family planning methods throughout the course of their reproductive lives is the key to reaching replacement fertility.

In addition, a separate phase of the organizational development intervention should assess the NFPB's relationships with other public and private sector groups so that the NFPB has a more realistic picture of how it is viewed in the community. This might enable it to reach out more effectively to other agencies and secure its coordinating role in the family planning community.